Appendix D

HEALTH ASSESSMENT QUESTIONNAIRES

This appendix contains two recommended health assessment questionnaires that may be used by medical personnel when conducting predeployment and redeployment medical screening. These questionnaires, filled out by the concerned contractor employee, are used along with provided medical records to assess whether or not an individual is medically fit to deploy to an AO and to assess possible long-term health impacts upon their return.

Pre-Deployment Health Assessment Questionnaire

INSTRUCTIONS: Please read each question carefully before marking your selections. Provide a response for each question. If you do not understand a question, ask the medical administrator conducting the medical screening.

DEMOGRAPHICS

Today's date (mm/dd/yy)

Anticipate deployment to

Last name

First name

Middle initial

Social security number
(or other identification number
if not a US citizen)

Date of birth

Gender
- [ ] Male
- [ ] Female

Supported military component (select only one)
- [ ] Army
- [ ] Air Force
- [ ] Navy

[ ] Marine Corps

Citizenship category (select only one)
[ ] US
[ ] TCN (list nationality) _____
[} Local national (list nationality) _____

HEALTH ASSESSMENT

1. Would you say your health in general is
   [ ] Excellent
   [ ] Very good
   [ ] Good
   [ ] Fair*
   [ ] Poor*

2. During the past 90 days, how often did you seek medical care for an illness?
   [ ] Never
   [ ] Once
   [ ] 2-4 times*
   [ ] 5 or more times*

3. During the past 90 days, how often did you seek medical care for an injury?
   [ ] Never
   [ ] Once
   [ ] 2-4 times*
   [ ] 5 or more times*

4. During the past 90 days, how many days of work did you miss due to illness or injury?
   [ ] None
   [ ] 1-6 days
   [ ] 7-15 days*
   [ ] 16 or more days*

5. During the past year, did you stay in any hospital or medical facility overnight or longer?
   [ ] No
   [ ] Yes*

6. Are you currently on light duty or other work restrictions?
   [ ] No
   [ ] Yes*

7. Do you currently have any dental problems?
   [ ] No
   [ ] Yes*

8. Do you currently have any medical problems?
   [ ] No
   [ ] Yes*

9. Do you have any allergies?
   [ ] No
   [ ] Yes*

10. Are you regularly taking any medications? (select all that apply)
   [ ] No, I am not taking any medications
   [ ] Over-the-counter medications
   [ ] Prescription medication*
   [ ] Birth control pills
   [ ] Vitamins
   [ ] Herbal supplements
   [ ] Malaria pills*

11. If you are taking prescription medications or birth control pills, do you have enough to last 90 days?
   [ ] No*
   [ ] Yes
   [ ] Not applicable

12. (For females) What was the result of your last PAP smear? Date of last WWE/PAP_____
   [ ] Normal
   [ ] Abnormal*
   [ ] Don't know*

13. (For females) Are you pregnant?
   [ ] No
   [ ] Yes
   [ ] I am not sure*

QUESTIONS 14-16 PERTAIN TO YOUR MENTAL HEALTH, WHICH INCLUDES ALCOHOL PROBLEMS, STRESS, DEPRESSION, AND EMOTIONAL PROBLEMS.

14. During the last 30 days, how many days was your mental health not good?
   [ ] None
   [ ] 1-5 days
   [ ] 6-10 days
   [ ] 11-15 days*
   [ ] 16 or more days*

15. During the last 30 days, how many days did your mental health keep you from your usual activities, such as self-care, work, or recreation?
   [ ] None
   [ ] 1-5 days
   [ ] 6-10 days
   [ ] 11-15 days*
   [ ] 16 or more days*

16. During the past year, have you sought counseling or care for your mental health?
   [ ] No
   [ ] Yes*

17. During the past 30 days, have you seriously considered injuring yourself or others?

[ ] No
[ ] Yes*

18. Have you ever suffered or sought treatment for any heat related injury such as heat stroke?
[ ] No
[ ] Yes*

19. Have you ever suffered or sought treatment for a cold injury such as frost bite or immersion foot?
[ ] No
[ ] Yes*

20. Do you currently have any questions or concerns about your health?
[ ] No
[ ] Yes*

21. Do you have concerns about exposure (such as environmental or work-related) that may affect your health?
[ ] No
[ ] Yes*

*Denotes that health care provider must follow-up!

END OF QUESTIONNAIRE

Pre-Deployment Health Provider Review
(for health provider only)

REVIEW

Indicate status of each of the following:

Yes	No	N/A	
[ ]	[ ]	[ ]	Medical threat briefing completed
[ ]	[ ]	[ ]	Medical information sheet distributed
[ ]	[ ]	[ ]	Pre-deployment serum specimen collected
[ ]	[ ]	[ ]	Exposure concerns reviewed (if yes, indicate type of exposure(s) reviewed)

X	Exposure Type
[ ]	Environment (air/soil/water)
[ ]	NBC warfare risks
[ ]	Immunizations
[ ]	Chemoprophalaxis
[ ]	Infectious diseases
[ ]	Occupational exposures (chemical, physical, biological)
[ ]	Other (list)_____

[ ]	[ ]	[ ]	Referred for further evaluation(s) (if yes, indicate type(s) of referral and disposition(s))

X	Referral Type
[ ]	Physical examination
[ ]	Dental examination

[ ] Infectious and parasitic diseases
[ ] Neoplasm
[ ] Endocrine-nutrition and metabolic disorders and immunity disorders
[ ] Diseases of the blood and blood-forming organs
[ ] Mental disorders
[ ] Diseases of the nervous system and sense organs
[ ] Diseases of the circulatory system
[ ] Diseases of the respiratory system
[ ] Diseases of the digestive system
[ ] Diseases of the genitourinary system
[ ] Diseases or conditions of the reproductive system
[ ] Diseases of the skin and subcutaneous tissue
[ ] Diseases of the musculoskeletal systemand connective tissue
[ ] Symptoms and signs of ill-defined conditions
[ ] Injury and poisoning
[ ] Other, list_____

Final medical disposition: [ ] Deploy [ ] Not Deploy (If not deployable, explain why)

I certify that this screening process has been completed.

Medical provider's signature and stamp:

Date:

Redeployment Health Assessment Questionnaire

INSTRUCTIONS: Please read each question carefully before marking your selections. Answer each question. If you do not understand a question, ask the medical administrator conducting the medical screening.

DEMOGRAPHICS

Today's Date (mm/dd/yy)

Anticipate deployment to

Last name

First name

Middle initial

Social security number
(or other identification number
if not a US citizen)

Date of birth

Gender
[ ] Male
[ ] Female

Supported military component (select only one)
[ ] Army
[ ] Air Force
[ ] Navy
[ ] Marine Corps

Citizenship category (select only one)
[ ] US
[ ] TCN (list nationality) _____
[} Local national (list nationality) _____

HEALTH ASSESSMENT

1. Would you say your health in general is—
[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair*
[ ] Poor*

2. Compared to before you were deployed, would you say your health in general is—
   [ ] Much better now
   [ ] Somewhat better now
   [ ] About the same now
   [ ] Somewhat worse now*
   [ ] Much worse now*

3. During this deployment, how often did you seek medical care for an illness?
   [ ] Never
   [ ] Once
   [ ] 2-4 times
   [ ] 5 or more times*

4. During this deployment, how often did you seek medical care for an injury?
   [ ] Never
   [ ] Once
   [ ] 2-4 times
   [ ] 5 or more times*

5. During this deployment, how many days of work did you miss due to illness?
   [ ] None
   [ ] 1-6 days
   [ ] 7-15 days*
   [ ] 16 days or more*

6. During this deployment, how many days of work did you miss due to injury?
   [ ] None
   [ ] 1-6 days
   [ ] 7-15 days*
   [ ] 16 days or more*

7. During this deployment, did you stay in any hospital or medical facility overnight or longer?
   [ ] No
   [ ] Yes*

8. Are you currently on light duty or other work restrictions??
   [ ] No
   [ ] Yes*

9. Do you currently have any dental problems?
   [ ] No
   [ ] Yes*

10. Do you currently have any medical problems?
   [ ] No
   [ ] Yes*

11. Are you regularly taking any medications? (select all that apply)
   [ ] No, I am not taking any medications
   [ ] Over-the-counter medications
   [ ] Prescription medication*
   [ ] Birth control pills

[ ] Malaria pills*

12. (For females) Are you pregnant?
    [ ] No
    [ ] Yes
    [ ] I am not sure*

QUESTIONS 13-15 PERTAIN TO YOUR MENTAL HEALTH, WHICH INCLUDES ALCOHOL PROBLEMS, STRESS, DEPRESSION AND EMOTIONAL PROBLEMS

13. During the last 30 days, how many days was your mental health not good?
    [ ] None
    [ ] 1-5 days
    [ ] 6-10 days
    [ ] 11-15 days*
    [ ] 16 or more days*

14. During the last 30 days, how many days did your mental health keep you from your usual activities, such as self-care, work, or recreation?
    [ ] None
    [ ] 1-5 days
    [ ] 6-10 days
    [ ] 11-15 days*
    [ ] 16 or more days*

15. During this deployment, have you sought counseling or care for your mental health?
    [ ] No
    [ ] Yes*

16. During this deployment, have you seriously considered injuring yourself or others?
    [ ] No
    [ ] Yes*

17. Do you have concerns about exposure (such as environmental or work-related) during this deployment that you feel may affect your health?
    [ ] No
    [ ] Yes*

18. During this deployment, have you suffered or sought treatment for any heat-related injury such as heat exhaustion?
    [ ] No
    [ ] Yes*

19. During this deployment, have you suffered or sought treatment for a cold injury such as frost bite or immersion foot?
    [ ] No
    [ ] Yes*

20. Do you currently have any questions or concerns about your health?
    [ ] No
    [ ] Yes*

* Denotes that health care provider must follow-up!

END OF QUESTIONNAIRE

Redeployment Health Provider Review
(for health provider only)

REVIEW

Indicate status of each of the following:

Yes	No	N/A	
[ ]	[ ]	[ ]	Medical threat briefing completed
[ ]	[ ]	[ ]	Medical information sheet distributed
[ ]	[ ]	[ ]	Pre-deployment serum specimen collected
[ ]	[ ]	[ ]	Exposure concerns reviewed (if yes, indicate type of exposure(s) reviewed)

X	Exposure Type
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[ ]	NBC warfare risks
[ ]	Immunizations
[ ]	Chemoprophalaxis
[ ]	Infectious diseases
[ ]	Occupational exposures (chemical, physical, biological)
[ ]	Others, list_____

[ ]	[ ]	[ ]	Referred for further evaluation(s) (if yes, indicate type(s) of referral and disposition(s))

X	Referral Type
[ ]	Physical examination
[ ]	Dental examination
[ ]	Infectious and parasitic diseases
[ ]	Neoplasm
[ ]	Endocrine-nutrition and metabolic disorders and immunity disorders
[ ]	Diseases of the blood and blood-forming organs
[ ]	Mental disorders
[ ]	Diseases of the nervous system and sense organs
[ ]	Diseases of the circulatory system
[ ]	Diseases of the respiratory system
[ ]	Diseases of the digestive system
[ ]	Diseases of the genitourinary system
[ ]	Diseases or conditions of the reproductive system
[ ]	Diseases of the skin and subcutaneous tissue
[ ]	Diseases of the musculoskeletal system and connective tissue
[ ]	Symptoms and signs of ill-defined conditions
[ ]	Injury and poisoning
[ ]	Other, list_____

Final medical disposition: [ ] Deploy [ ] Not Deploy (If not deployable, explain why)

I certify this screening process has been completed.

Medical provider's signature and stamp:

Date: